FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044347

Facility Name: BLOOMINGDALE PAVILION

Address: 311 EDGEWATER DRIVE (Number) BLOOMINGDALE (City) 60108 (Zip Code)

County: DUPAGE

Telephone Number: (630) 894-7400 **Fax #** (630) 894-8528

IDPA ID Number: 364214316001

Date of Initial License for Current Owners: 05/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) MARVIN FOX, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	259	Skilled (SNF)	259	94,535	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	259	TOTALS	259	94,535	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	27,864	3,843	11,483	43,190	8
9	SNF/PED					9
10	ICF	22,974	3,498		26,472	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,838	7,341	11,483	69,662	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.69%

D. How many bed-hold days during this year were paid by Public Aid?
O (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 259 and days of care provided 7,723

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	348,384	28,060	21,855	398,299		398,299	2,461	400,760			1
2	Food Purchase		279,452		279,452	(32,303)	247,150	(293)	246,856			2
3	Housekeeping	164,143	32,853	85,613	282,609		282,609		282,609			3
4	Laundry	55,667	26,644	45,647	127,958		127,958		127,958			4
5	Heat and Other Utilities			177,911	177,911		177,911	1,306	179,217			5
6	Maintenance	86,886		112,972	199,858		199,858	(9,329)	190,529			6
7	Other (specify):*							1,729	1,729			7
8	TOTAL General Services	655,080	367,009	443,998	1,466,087	(32,303)	1,433,785	(4,127)	1,429,658			8
	B. Health Care and Programs											
9	Medical Director			19,525	19,525		19,525		19,525			9
10	Nursing and Medical Records	4,034,666	248,261	30,633	4,313,560		4,313,560	8,221	4,321,781			10
10a	Therapy	179,206	13,762	6,436	199,404		199,404	(11,306)	188,098			10a
11	Activities	168,851	10,914	1,858	181,623		181,623		181,623			11
12	Social Services	103,647		2,935	106,582		106,582		106,582			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							2,280	2,280			15
16	TOTAL Health Care and Programs	4,486,370	272,937	61,387	4,820,694		4,820,694	(805)	4,819,889			16
	C. General Administration											
17	Administrative	75,194		420,532	495,726		495,726	(151,787)	343,939			17
18	Directors Fees											18
19	Professional Services			42,344	42,344		42,344	530	42,874			19
20	Dues, Fees, Subscriptions & Promotions			69,198	69,198		69,198	(38,774)	30,424			20
21	Clerical & General Office Expenses	205,221	60,188	376,699	642,108		642,108	(242,468)	399,640			21
22	Employee Benefits & Payroll Taxes			954,546	954,546	32,303	986,849		986,849			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,486	18,486		18,486	(3,006)	15,480			24
25	Other Admin. Staff Transportation							22	22			25
26	Insurance-Prop.Liab.Malpractice			207,499	207,499		207,499	1,523	209,022			26
27	Other (specify):*							22,079	22,079			27
28	TOTAL General Administration	280,415	60,188	2,089,304	2,429,907	32,303	2,462,210	(411,881)	2,050,329			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,421,865	700,134	2,594,689	8,716,688		8,716,688	(416,812)	8,299,876			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BLOOMINGDALE PAVILION #0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			117,387	117,387		117,387	(37,779)	79,608			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			347,840	347,840		347,840	2,365	350,205			32
33	Real Estate Taxes			184,367	184,367		184,367		184,367			33
34	Rent-Facility & Grounds			1,083,742	1,083,742		1,083,742	11,199	1,094,941			34
35	Rent-Equipment & Vehicles			22,439	22,439		22,439	614	23,053			35
36	Other (specify):*			24,528	24,528		24,528		24,528			36
37	**TOTAL Ownership**			1,780,303	1,780,303		1,780,303	(23,601)	1,756,702			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	469,878	648,311	622,116	1,740,305		1,740,305	(18,388)	1,721,917			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,803	141,803		141,803		141,803			42
43	Other (specify):*	38,685		63,765	102,450		102,450	(102,451)	(1)			43
44	**TOTAL Special Cost Centers**	508,563	648,311	827,684	1,984,558		1,984,558	(120,839)	1,863,719			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,930,428	1,348,445	5,202,676	12,481,549		12,481,549	(561,252)	11,920,297			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(51,443)	30		9
10	Interest and Other Investment Income	(295)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(293)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,947)	21		18
19	Entertainment	(1,258)	24		19
20	Contributions	(468)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(285,833)	21		24
25	Fund Raising, Advertising and Promotional	(35,228)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,425)	20		28
29	Other-Attach Schedule	(140,326)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (523,515)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(37,737)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (37,737)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (561,252)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

BLOOMINGDALE PAVILION

ID# 0044347

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VAN DRIVERS	$ (12,537)	43	1
2	MARKETING SALARY	(26,148)	43	2
3	CAPITALIZED REPAIRS AND MAINTENANCE	(11,298)	06	3
4	BANK CHARGES	(14,428)	21	4
5	COPE - ILLINOIS COUNCIL	(1,447)	20	5
6	NON ALLOWABLE LEGAL FEES	(8,587)	19	6
7	VAN COMMUTING EXPENSE	(63,152)	43	7
8	UNALLOWABLE TRAVEL	(2,727)	24	8
9				9
10				10
11				11
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100				100
101	Total	(140,326)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				2,561		(100)						2,461	1
2	Food Purchase	(293)											(293)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities					1,306							1,306	5
6	Maintenance	(11,298)				423	1,546						(9,329)	6
7	Other (specify):*						1,729						1,729	7
8	**TOTAL General Services**	(11,592)			2,561	1,729	3,175						(4,127)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(8,165)	16,386							8,221	10
10a	Therapy			34			(11,340)						(11,306)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*					2,280							2,280	15
16	**TOTAL Health Care and Programs**			34	(8,165)	18,666	(11,340)						(805)	16
	C. General Administration													
17	Administrative					79,511		(231,298)					(151,787)	17
18	Directors Fees													18
19	Professional Services	(8,587)				8,136	(243,970)	244,951					530	19
20	Fees, Subscriptions & Promotions	(43,568)				4,756		38					(38,774)	20
21	Clerical & General Office Expenses	(302,208)				86,776		(27,036)					(242,468)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(3,985)				979							(3,006)	24
25	Other Admin. Staff Transportation					22							22	25
26	Insurance-Prop.Liab.Malpractice					1,599		(76)					1,523	26
27	Other (specify):*					20,529		1,550					22,079	27
28	**TOTAL General Administration**	(358,348)				202,308	(243,970)	(11,871)					(411,881)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(369,939)		34	(5,604)	222,703	(252,135)	(11,871)					(416,812)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(51,443)				4,435		9,229					(37,779)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(295)				1,190		1,470					2,365	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds					11,199							11,199	34
35	Rent-Equipment & Vehicles						614						614	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(51,738)				16,824	614	10,699					(23,601)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			4,077	(22,465)								(18,388)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(101,838)					(613)						(102,451)	43
44	**TOTAL Special Cost Centers**	(101,838)		4,077	(22,465)		(613)						(120,839)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(523,515)		4,111	(28,069)	239,527	(252,134)	(1,172)					(561,252)	45

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 2,329	Advanced Therapy and Rehab, LLC	100.00%	$ 2,363	$ 34	15
16	V	39	ANCILLARY REHAB	279,225	Advanced Therapy and Rehab, LLC	100.00%	283,302	4,077	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 281,554			$ 285,665	$ * 4,111	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 37,132	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 14,667	$ (22,465)	15
16	V	10	MEDICAL SUPPLIES	9,263	QUALITY CARE MEDICAL SUPPLY	100.00%	1,098	(8,165)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	2,561	2,561	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 46,395			$ 18,326	$ * (28,069)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 1,306	$ 1,306	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	423	423	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,670	6,670	17
18	V	10	SAL-NURSING-M. DEAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	9,716	9,716	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,280	2,280	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,384	5,384	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	16,754	16,754	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,535	6,535	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	14,469	14,469	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,542	8,542	24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	11,214	11,214	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	13,982	13,982	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,631	2,631	27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,136	8,136	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,756	4,756	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	82,902	82,902	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,874	3,874	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	979	979	32
33	V	25	OTHER ADMIN. STAFF TRANS.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	22	22	33
34	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,599	1,599	34
35	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	20,529	20,529	35
36	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,435	4,435	36
37	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,190	1,190	37
38	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	11,199	11,199	38
39	Total			$			$ 239,527	$ * 239,527	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	614	$ 614	15
16	V	19	CORP ALLOC/MGMT FEE	243,970	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	(243,970)	16
17	V	6	REPAIRS AND MAINT.	9,360	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,906	1,546	17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,471	1,471	18
19	V	10	NURSE CONSULTANT		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			19
20	V	1	DIETICIAN SALARIES	2,010	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,910	(100)	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	258	258	21
22	V	10A	RESPIRATORY THERAPIST	11,340	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(11,340)	22
23	V	43	MARKETING CONSULTANT	613	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(613)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 267,293			$ 15,159	$ * (252,134)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	INSURANCE	$	QUALITY CARE MANAGEMENT	100.00%	$ (76)	$ (76)	15
16	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	6,336	6,336	16
17	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	4,489	4,489	17
18	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	1,847	1,847	18
19	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	981	981	19
20	V	19	MGNT FEES-DIRECT ALLOC		QUALITY CARE MANAGEMENT	100.00%	243,970	243,970	20
21	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	38	38	21
22	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	(3,036)	(3,036)	22
23	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	1,550	1,550	23
24	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	9,229	9,229	24
25	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	1,470	1,470	25
26	V								26
27	V								27
28	V	17	CORPORATE ALLOCATION	243,970	QUALITY CARE MANAGEMENT	100.00%		(243,970)	28
29	V	21	COMPUTER SERVICES	24,000	QUALITY CARE MANAGEMENT	100.00%		(24,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 267,970			$ 266,798	$ * (1,172)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DAVID MEISELS	OWNER	ADMIN	45.00%	SEE ATTACHED	5	9.09%		$		1
2	BRIAN CLOCH	OWNER	ADMIN	45.00%	SEE ATTACHED	5.52	8.49%	ALO QCARE	1,015	39-7	2
3	BRIAN CLOCH	OWNER	ADMIN		SEE ATTACHED			SAL BLVD	14,469	17-07	3
4	BRIAN CLOCH	OWNER	ADMIN		SEE ATTACHED			SAL QCARE	6,336	17-07	4
5	BRUCHA TEITELBAUM	OWNER	ADMIN	10.00%	SEE ATTACHED	0.96	2.40%	SAL QCARE	4,489	17-07	5
6	JOSEPH MEISELS	RELATIVE	ADMIN	0.00%	SEE ATTACHED	3.85	7.70%	SAL QCARE	1,847	17-07	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 28,156		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATN						2,363	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATN						283,302	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 285,665	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATN						14,667	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATN						1,098	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATN						2,561	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 18,326	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	404,328	8	$ 18,054	$	29,252	$ 1,306	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	404,328	8	5,848		29,252	423	2
3	10	NURSING	PATIENT DAYS	404,328	8	92,189	90,660	29,252	6,670	3
4	10	SAL-NURSING-M. DEAL	PATIENT DAYS	404,328	8	134,295	134,295	29,252	9,716	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	404,328	8	31,517		29,252	2,280	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	404,328	8	74,422	74,422	29,252	5,384	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	404,328	8	231,575	231,575	29,252	16,754	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	404,328	8	90,333	90,333	29,252	6,535	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	404,328	8	200,000	200,000	29,252	14,469	9
10	17	ADMIN. SAL. - C. ROSS	PATIENT DAYS	404,328	8	118,071	118,071	29,252	8,542	10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	404,328	8	155,000	155,000	29,252	11,214	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	404,328	8	193,262	193,262	29,252	13,982	12
13	17	ADMIN. SAL. - J. ELOWE	PATIENT DAYS	404,328	8	36,364	36,364	29,252	2,631	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	404,328	8	112,461		29,252	8,136	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	404,328	8	65,740		29,252	4,756	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	404,328	8	1,145,893	1,000,220	29,252	82,902	16
17	21	SALARIES-ACCTG-B. LARIMO	PATIENT DAYS	404,328	8	53,541	53,541	29,252	3,874	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	404,328	8	13,535		29,252	979	18
19	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	404,328	8	300		29,252	22	19
20	26	INSURANCE	PATIENT DAYS	404,328	8	22,107		29,252	1,599	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	404,328	8	283,762		29,252	20,529	21
22	30	DEPRECIATION	PATIENT DAYS	404,328	8	61,299		29,252	4,435	22
23	32	INTEREST	PATIENT DAYS	404,328	8	16,452		29,252	1,190	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	404,328	8	154,799		29,252	11,199	24
25	TOTALS					$ 3,310,819	$ 2,377,744		$ 239,527	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	404,328	8	8,483		29,252	614	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	12,688	2	14,784	14,784	9,360	10,906	3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	12,688	2	1,994		9,360	1,471	4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	41,225	8	39,169	39,169	2,010	1,910	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	41,225	8	5,282		2,010	258	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 69,712	$ 53,953		$ 15,159	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	INSURANCE	PATIENT DAYS	152,042	5	$ (394)	$ (394)	29,252	$ (76)	1
2	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	152,042	5	32,933	32,933	29,252	6,336	2
3	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	152,042	5	23,333	23,333	29,252	4,489	3
4	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	152,042	5	9,600	9,600	29,252	1,847	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	152,042	5	5,097		29,252	981	5
6	19	MGNT FEES-DIRECT ALLOC	DIRECT ALLOCATION		5	857,602			243,970	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	152,042	5	200		29,252	38	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	152,042	5	(15,781)		29,252	(3,036)	8
9	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	152,042	5	8,058		29,252	1,550	9
10	30	DEPRECIATION	PATIENT DAYS	152,042	5	47,971		29,252	9,229	10
11	32	INTEREST	PATIENT DAYS	152,042	5	7,643		29,252	1,470	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 976,262	$ 65,472		$ 266,798	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	YESHIVA		X	WORKING CAPITAL			800,000	800,000	DEMAND	8.00%	64,000	6
7	DVI		X	WORKING CAPITAL	VARIES			2,531,536		PRM+2%	155,173	7
8	CONTINENTAL CARE	X		WORKING CAPITAL	$10,915.00	03/20/01	1,300,000	1,243,926	08/01/19	PRM+.5%	88,535	8
9	TOTAL Facility Related				$10,915.00		$ 2,100,000	$ 4,575,463			$ 307,708	9
	B. Non-Facility Related*											
10	See Supplemental Schedule						1,432,990	317,687			42,792	10
11	INTEREST INCOME		X								(296)	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 1,432,990	$ 317,687			$ 42,496	14
15	TOTALS (line 9+line14)						$ 3,532,990	$ 4,893,149			$ 350,205	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	MANUFACTURER'S BANK		X	WORKING CAPITAL	VARIES	5/28/98	$ 900,000	$ 145,516	DEMAND	PRM+1%	$ 10,170	1
2	VIASYS		X	EQUIPMENT	3,009	06/01/01	132,990	100,709	05/01/06	13.24%	13,545	2
3	BANK LEUMI		X	WORKING CAPITAL	VARIES	5/24/00	400,000	71,462	06/01/03	PRM+.5%	16,417	3
4	ALLOC FROM BLVD HC	X									1,190	4
5	ALLOC QUALITY CARE	X									1,470	5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$ 1,432,990	$ 317,687			$ 42,792	21

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 180,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 177,167	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,833)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 187,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 184,367	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998	113,308	9
1999	169,114	10
2000	171,706	11
2001	177,167	12

2002 accrual = 2001 actual tax X 1.057 (177,167 X 1.057 = 187,267. Use 187,200)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BLOOMINGDALE PAVILION COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0044347

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847)-236-1111 FAX #: (847)-236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-23-124-022	NURSING HOME	$ 177,166.76	$ 177,166.76
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 177,166.76	$ 177,166.76

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BLOOMINGDALE PAVILION COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0044347

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE _____ FAX #: _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,047 B. General Construction Type: Exterior MASONRY Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: ORGANIZATION COSTS, UNAMORTIZED LINE OF CREDIT
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	80,688		20	4,034	4,034	17,245	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		7,066	895		895		895	68
69	Financial Statement Depreciation			17,771			(17,771)		69
70	TOTAL (lines 4 thru 69)		$ 87,754	$ 18,666		$ 4,929	$ (13,737)	$ 18,140	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 87,754	$ 18,666		$ 4,929	$ (13,737)	$ 18,140	1
2	FIRE ALARM WORK	1999	4,013		20	201	201	804	2
3	CARPETING	1999	3,218		20	161	161	644	3
4	FIRE DOOR	1999	1,348		20	67	67	257	4
5	FENCE	1999	1,705		20	85	85	305	5
6	ELEC OUTLETS	1999	635		20	32	32	115	6
7	AC COMPRESSOR	1999	3,286		20	164	164	588	7
8	OUTDOOR SHED	1999	1,277		20	64	64	219	8
9	FIRE ALARM WORK	1999	6,105		20	305	305	1,068	9
10	SHED MATERIALS	1999	1,357		20	68	68	227	10
11	COVE BASE	1999	701		20	35	35	117	11
12	WALLCOVERINGS	1999	962		20	48	48	160	12
13	WALLPAPER	1999	966		20	48	48	160	13
14	HAND RAILS	1999	15,358		20	768	768	2,560	14
15	WALLPAPER	1999	1,397		20	70	70	228	15
16	HANDRAILS	1999	15,358		20	768	768	2,496	16
17	WALLPAPER	1999	5,319		20	266	266	865	17
18	ELECTRICAL WORK	1999	985		20	49	49	155	18
19	GENERATOR WIRING	1999	709		20	35	35	111	19
20	FIRE ALARM SYSTEM	1999	5,500		20	275	275	917	20
21	WANDERGUARD MONITOR	1999	1,049		20	52	52	204	21
22	PAINTING & DEC	1999	3,049		20	152	152	532	22
23	GENERATOR REPAIRS	1999	1,346		20	67	67	223	23
24	FIBERGLASS WALLCOVER	1999	1,178		20	59	59	182	24
25	KEYPAD ENTRY SYSTEM	2000	5,146		20	257	257	1,543	25
26	FLOOR TILE	2000	1,074		20	54	54	135	26
27	FLOORING	2000	10,111		20	506	506	1,260	27
28	WALL COVERING	2000	1,180		20	118	118	472	28
29	BORDER	2000	834		20	42	42	251	29
30	SPRINKLER	2000	1,050		20	53	53	130	30
31	HANDRAIL	2000	2,000		20	100	100	240	31
32	BORDER	2000	507		20	25	25	152	32
33	WALLCOVERINGS	2000	1,179		20	59	59	354	33
34	TOTAL (lines 1 thru 33)		$ 187,656	$ 18,666		$ 9,982	$ (8,684)	$ 35,814	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 187,656	$ 18,666		$ 9,982	$ (8,684)	$ 35,814	1
2	ELECTRIC WIRING	2000	2,077		20	104	104	241	2
3	DOOR	2000	718		20	36	36	77	3
4	BOILER	2000	1,000		20	50	50	108	4
5	MIRRORS	2000	674		20	34	34	203	5
6	MIRRORS	2000	700		20	35	35	210	6
7	DOORS	2000	1,278		20	64	64	138	7
8	INTERCOM SYSTEM	2000	3,855		20	193	193	398	8
9	INST MIRRORS	2000	582		20	29	29	175	9
10	PAGING SYSTEM	2000	1,178		20	59	59	119	10
11	WINDOW TREATMENT	2000	1,474		20	74	74	148	11
12	INTERIOR SIGNAGE	2000	3,687		20	184	184	368	12
13	COMPRESSOR	2000	1,613		20	81	81	162	13
14	ROOFING	2000	525		20	26	26	52	14
15	CUBICLE CURTAINS	2000	515		20	26	26	52	15
16	COVE BASE	2000	829		20	41	41	82	16
17	WALLPAPER	2000	888		20	44	44	88	17
18	WALLCOVERING	2000	935		20	47	47	94	18
19	HEAT/COOL SYSTEM	2001	3,315		20	166	166	318	19
20	HEAT/COOL SYSTEM	2001	703		20	35	35	53	20
21	WATER HEATER	2001	2,992		20	150	150	225	21
22	REPIPE RANGE GUARD	2001	738		20	37	37	52	22
23	SPRINKLER SYSTEM REP	2001	4,850		20	243	243	344	23
24	SPRINKLER SYSTEM REP	2001	1,025		20	51	51	72	24
25	TRANSFORMER WORK	2001	5,259		20	263	263	329	25
26	HEAT/COOL SYSTEM	2001	777		20	39	39	42	26
27	ROOFING WORK	2001	4,000		20	200	200	217	27
28	TOILET	2001	692		20	35	35	64	28
29	A/C REPAIR	2001	576		20	29	29	46	29
30	A/C RECHARGE	2001	650		20	33	33	52	30
31	REPLACE COMPRESSOR	2001	524		20	26	26	41	31
32	REPR DOOR BRACKET	2001	529		20	26	26	37	32
33	DECORATE MAIN ENTRY	2001	2,055		20	103	103	146	33
34	TOTAL (lines 1 thru 33)		$ 238,869	$ 18,666		$ 12,545	$ (6,121)	$ 40,567	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 238,869	$ 18,666		$ 12,545	$ (6,121)	$ 40,567	1
2	SHEET FLOORING	2001	541		20	27	27	32	2
3	LIGHT POLES OUTLETS	2002	500		20	4	4	4	3
4	WALKIN REFRIGERATOR REPAIR	2002	2,470		20	137	137	137	4
5	REPLACE REFRIGERATION UNIT	2002	3,525		20	196	196	196	5
6	ROOF TOP HVAC UNIT	2002	7,700		20	374	374	374	6
7	4 PTAC UNITS	2002	3,300		20	39	39	39	7
8	INSTALL DOOR HOLDERS	2002	825		20	69	69	69	8
9	INSTALL KNOB LOCKS	2002	849		20	71	71	71	9
10	DOOR MONITORING SYSTEM	2002	18,401		20	219	219	219	10
11	FIRE RATED DOORS & FRAMES	2002	1,773		20	190	190	190	11
12	KEYPAD FOR FRONT DOOR	2002	1,137		20	149	149	149	12
13	NEW ROOF	2002	102,475		20	7,686	7,686	7,686	13
14	ROOF REPAIR	2002	9,018		20	827	827	827	14
15	GLASSES AND FRAMES	2002	1,223		20	112	112	112	15
16	CARPETING	2002	10,672		20	889	889	889	16
17	CARPETING	2002	1,364		20	16	16	16	17
18	ROOF TOP A/C UNITS	2002	2,675		20	111	111	111	18
19	REPLACE ROOF ANTENA	2002	800		20	37	37	37	19
20	GENERATOR REPAIRS	2002	821		20	38	38	38	20
21	REPAIR CALL LIGHTS	2002	842		20	39	39	39	21
22	DOOR CLOSERS	2002	777		20	32	32	32	22
23	DOOR REPAIR NURSING	2002	1,279		20	21	21	21	23
24	CALL STATION SERVICE	2002	2,333		20	39	39	39	24
25	A/C REPAIR	2002	642		20	3	3	3	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 414,811	$ 18,666		$ 23,870	$ 5,204	$ 51,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOC FROM BOULEVARD HC MANGMT, LLC			2002	7,066	895	20	895		895	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,066	$ 895		$ 895	$	$ 895	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 510,530	$ 107,119	$ 51,861	$ (55,258)	10	$ 147,509	71
72	Current Year Purchases	41,903	5,265	3,876	(1,389)	10	3,876	72
73	Fully Depreciated Assets	43,168				10	43,168	73
74								74
75	TOTALS	$ 595,601	$ 112,384	$ 55,737	$ (56,647)		$ 194,553	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	1,010,412	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	131,050	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	79,607	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(51,443)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	246,450	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: TRUST NO. 10-30397-09

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		259	05/01/98	$ 1,080,000	13		3
4	Additions							4
5	STORAGE				3,742			5
6	ALLOC BLVD HC MGMT,LLC				11,199			6
7	TOTAL		259		$ 1,094,941 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [X] YES [ ] NO Terms: AFTER 01/01/08, $ 17,612,000 *

10. Effective dates of current rental agreement:
Beginning 09/01/01
Ending 12/31/11

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ 1,080,000
13.	/2004	$ 1,080,000
14.	/2005	$ 1,080,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 19,166 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2003 FORD E350 VAN	$ 537.41	$ 3,887	17
18					18
19					19
20					20
21	TOTAL		$ 537.41	$ 3,887	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	$ 15,160		$ 112,946	$		$ 128,106	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	7,737		79,345			87,082	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	60,868		400,984			461,852	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				256,270		256,270	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 01		386,113					386,113	12
13	Other (specify): See Supplemental					28,841	392,041		420,882	13
14	TOTAL			$ 469,878		$ 622,116	$ 648,311		$ 1,740,305	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,100	$	1
2	Cash-Patient Deposits	54,905		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,512,325		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	158,842		6
7	Other Prepaid Expenses	29,500		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	250,460		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,007,132	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	369,868		15
16	Equipment, at Historical Cost	495,252		16
17	Accumulated Depreciation (book methods)	(381,731)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	1,412,531		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,895,920	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,903,052	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,952,733	$	26
27	Officer's Accounts Payable	15,983		27
28	Accounts Payable-Patient Deposits	54,405		28
29	Short-Term Notes Payable	4,893,149		29
30	Accrued Salaries Payable	271,879		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,130		31
32	Accrued Real Estate Taxes(Sch.IX-B)	187,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	72,982		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,479,461	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,479,461	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,576,409)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,903,052	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,831,524)	1	
2	Restatements (describe):		2	
3	RESTATEMENT OF PRIOR YEARS MANAGEMENT FEES	136,516	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,695,008)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(881,401)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (881,401)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,576,409)	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,523,360	1
2	Discounts and Allowances for all Levels	(2,847,498)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,675,862	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,746,297	6
7	Oxygen	160,717	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,907,014	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	637,144	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	121,659	19
20	Radiology and X-Ray	8,565	20
21	Other Medical Services	247,913	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,015,281	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	295	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 295	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,696	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,696	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,600,148	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,466,087	31
32	Health Care	4,820,694	32
33	General Administration	2,429,907	33
	B. Capital Expense		
34	Ownership	1,780,303	34
	C. Ancillary Expense		
35	Special Cost Centers	1,842,755	35
36	Provider Participation Fee	141,803	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,481,549	40
41	**Income before Income Taxes (line 30 minus line 40)****	(881,401)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (881,401)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,749	2,070	$ 74,629	$ 36.06	1
2	Assistant Director of Nursing	2,252	2,409	66,702	27.69	2
3	Registered Nurses	66,805	84,158	1,880,942	22.35	3
4	Licensed Practical Nurses	14,670	18,503	342,491	18.51	4
5	Nurse Aides & Orderlies	115,629	181,516	1,619,491	8.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	21,754	25,827	469,878	18.19	7
8	Rehab/Therapy Aides	10,102	11,618	179,206	15.43	8
9	Activity Director	1,887	2,189	34,786	15.89	9
10	Activity Assistants	11,432	12,790	134,065	10.48	10
11	Social Service Workers	6,150	6,758	103,647	15.34	11
12	Dietician					12
13	Food Service Supervisor	3,155	4,016	68,017	16.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,365	31,950	280,367	8.78	15
16	Dishwashers					16
17	Maintenance Workers	4,276	5,177	86,886	16.78	17
18	Housekeepers	20,925	21,664	164,143	7.58	18
19	Laundry	7,824	8,018	55,667	6.94	19
20	Administrator	1,838	2,067	69,987	33.86	20
21	Assistant Administrator	139	234	5,207	22.22	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,611	13,845	205,221	14.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,360	2,621	50,411	19.23	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,409	2,475	38,686	15.63	33
34	TOTAL (lines 1 - 33)	334,332	439,904	$ 5,930,429 *	$ 13.48	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	486	$ 21,855	01-03	35
36	Medical Director	149	19,525	09-03	36
37	Medical Records Consultant	32	1,376	10-03	37
38	Nurse Consultant	406	18,281	10-03	38
39	Pharmacist Consultant	142	5,130	10-03	39
40	Physical Therapy Consultant	84	3,751	10a-03	40
41	Occupational Therapy Consultant	60	2,685	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,858	11-03	44
45	Social Service Consultant	61	2,935	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,468	$ 77,396		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 320	10-03	50
51	Licensed Practical Nurses	117	5,526	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	125	$ 5,846		53

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AIMEE MUSIAL	ADMINISTRATOR	0	$ 75,193
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,193

B. Administrative - Other

Description	Amount
QUALITY CARE - MANAGEMENT FEE	$ 243,970
OLYMPIA GROUP - MANAGEMENT FEE	176,563
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 420,532

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE	LEGAL	$ 15,196
PERSONNEL PLANNERS	UNEMPLOYMENT CONSLT	1,179
FROST,RUTTENBERG & ROTHBL	ACCOUNTING	16,923
DVI	ACCOUNTING	5,279
DOCUMENT SOLUTIONS	A/R CONSULTING	1,138
BRIDGEMARK, LLC	COMPLIANCE PLANNING	2,000
PENSION RESOURCES	PENSION CONSULT.	630
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 42,344

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,429
Unemployment Compensation Insurance	88,621
FICA Taxes	439,783
Employee Health Insurance	180,279
Employee Meals	32,303
Illinois Municipal Retirement Fund (IMRF)*	
HOLIDAY EXPENSE	2,620
EMPLOYEE RECRUITMENT	500
DISABILITY INSURANCE	35,078
LIFE INSURANCE	4,271
EMPLOYEE BENEFITS	39,176
401 K EXPENSE	18,789
TOTAL (agree to Schedule V, line 22, col.8)	$ 986,847

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
LICENSES,PERMITS AND FEES	1,975
DUES & SUBSCRIPTIONS	14,199
YELLOW PAGES ADS	6,425
ADVERTISING & PROMOTION	35,228
CLASSIFIED ADVERTISING	9,456
SEE SEPARATE SCHEDULE	4,794
Less: Public Relations Expense	( )
Non-allowable advertising	(35,228)
Yellow page advertising	(6,425)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,424

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,619
TRANSPORTATION/TRAVEL	10,861
MEALS AND ENTERTAINMENT	1,258
Entertainment Expense	(1,258)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,480

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL $ 14,367

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 24,572 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 141,803
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 32,303 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%in14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees